



Kelly, C., Tumblety, J., & Sheron, N. (2016). Histories of Medical Lobbying. *Lancet*, 388(10055), 1976-1977.
[https://doi.org/10.1016/S0140-6736\(16\)31860-8](https://doi.org/10.1016/S0140-6736(16)31860-8)

Peer reviewed version

License (if available):
CC BY-NC-ND

Link to published version (if available):
[10.1016/S0140-6736\(16\)31860-8](https://doi.org/10.1016/S0140-6736(16)31860-8)

[Link to publication record in Explore Bristol Research](#)
PDF-document

This is the author accepted manuscript (AAM). The final published version (version of record) is available online via Elsevier at <http://www.sciencedirect.com/science/article/pii/S0140673616318608>. Please refer to any applicable terms of use of the publisher.

University of Bristol - Explore Bristol Research

General rights

This document is made available in accordance with publisher policies. Please cite only the published version using the reference above. Full terms of use are available:
<http://www.bristol.ac.uk/red/research-policy/pure/user-guides/ebr-terms/>

‘Histories of medical lobbying’

The lobbying of government ministers by medical professionals is a live issue. In Britain and around the world medical practitioners have become active in the pursuit of legislative change. In the UK, the AllTrials campaign co-founded by the physician-researcher Ben Goldacre continues to exert pressure on parliamentarians in a bid to force greater transparency in the publication of clinical trial results. Meanwhile, the California Medical Association advocates the legalisation of the recreational use of marijuana, and doctors in Australia refuse to release child refugees from hospital into detention centres damaging to their mental health. It was precisely the lobbying of medical humanitarians such as Médecins sans Frontières in France that effected a change in the law there in 1998, permitting undocumented immigrants with life-threatening conditions to remain in the country for medical treatment.

Each of these examples represents an organised attempt on the part of medical professionals to change government policy on matters related to public health – in other words, lobbying. Yet a recent announcement by the UK cabinet office suggests that henceforth recipients of public funding will be banned from directly lobbying government ministers in the hope of changing public policy. When questioned in parliament David Cameron stated that charities should be devoting themselves to ‘good causes’ rather than ‘lobbying ministers’. Unless some qualification is forthcoming, medical researchers too will be proscribed from carrying out such activity. This insinuates that lobbying is in some way outside the proper remit of researchers, medical or otherwise.

Yet even a cursory glance at the history of the medical profession’s engagement with public health reveals a longstanding and significant engagement with the political process. Medical professionals have been using their scientific expertise as leverage

in this way for at least two hundred years. Indeed, the further professionalization of medicine in the 19th century, which brought the regulation of practice, changes to medical education, and the rise of hospital medicine and laboratory research coincided with an increase in parliamentary activity in much of the European and North American world. It also ran parallel to the expansion of industrial cities, whose physically deprived populations prompted widespread acknowledgement of a 'social question' in which medical professionals often wished to intervene. By the late 19th century one can even speak, as does the historian Jack Ellis, of a 'hygienic crusade throughout Europe', powered by the efforts of physicians 'to shift the bacteriological revolution from a scientific to a political plane'. If the battle against contagious diseases and poor sanitation became a sanctioned sphere of parliamentary action in this period, the process of it becoming so owes much to the initiative of doctors.

Lobbying strategies have been varied, and variable in their success. The term itself developed in the United States in the middle decades of the 19th century, when it referred to the process of frequenting the lobby of a legislative assembly for the purpose of influencing members' votes. The practice, however, pre-dated the word. It was embraced enthusiastically in the early 19th century by Dr Charles Maclean, one of the era's most strident medical campaigners. Maclean had become convinced that the plague was not contagious, and accordingly that quarantine measures imposed on ships were unnecessary and positively harmful to health and trade. His attempts to persuade colleagues, the public, the East India Company and influential politicians such as Sir John Jackson resulted in two parliamentary select committee inquiries in 1819 and 1824. As a result, there was some softening of the quarantine laws (although not the complete abolition Maclean had desired). Like other radicals at this time, Maclean's approach was strident and provocative. He engaged in deliberate attention-seeking behaviour in his attempts to change the views of

individual politicians and Parliament, believing that this was the best way for his unorthodox views to gain traction.

Some of the most prominent and successful public health campaigns of the 19th century hinged on the ability of medical advocates to secure the support of influential politicians. The social reformer Edwin Chadwick relied heavily on the medical support of Thomas Southwood Smith to secure the Public Health Act in 1848. Following that enactment, a medical lobbyist working within public administration, John Simon (then Medical Officer of Health to the Sewers Commission of the City of London), used his annual reports and close connections at *The Times* to convince the public of the importance of his proposed environmentalist measures to promote urban sanitation and hygiene. By the mid-1850s Simon's perseverance had won over many who had opposed his views, and in 1859 he became the Medical Officer to the Privy Council, providing him with direct ministerial access to further his work.

Innovative medical procedures similarly required political support: Edward Jenner's success in persuading the public to vaccinate owed no small debt to his political patrons who helped to secure him a reward in Parliament, thus making the 'universal approbation of the House of Commons' for vaccination widely known. Parliament gave further practical support to Jenner's mission by funding the National Vaccine Establishment in 1809. Similarly, the lobbying efforts of the Epidemiological Society (a medical pressure group) were crucial in countering opponents of vaccination and securing the Vaccination Act in 1853 requiring all infants to be vaccinated within three months of birth.

Over time, the medical profession created its own elite bodies designed, in part, to channel the collective power of medical expertise on such questions. If the British Medical Association (formed in 1832) initially eschewed politics, and has always

sought party political neutrality, its creation in the 20th century of a parliamentary medical committee and its use of parliamentary agents, points to the willingness of the organisation to engage as directly as possible in the law-making process.

Medical lobbying was equally important in the development of other European health systems. In France, a remarkable number of physicians were legislators themselves, effecting change from within the system. In the early Third Republic (1870-1914) doctors were the second most commonly represented professional group in parliament after lawyers: 358 of them were elected as deputies or senators in these years. In 1873, Dr Théophile Roussel led the reform of wet nursing, a practice unusually prolific in France due to the upsurge of fulltime working women there after mid-century, and one that was linked to high infant mortality. Prompted by the pressure brought to bear by fellow members of the Academy of Medicine, Roussel successfully introduced a parliamentary Bill in 1873 to regulate wet-nursing practices through a state system of compulsory registration, surveillance and medical inspection. Whether as legislators themselves or members of parliamentary committees, French medics successfully argued for the regulation of a host of public health menaces in this period – factory conditions, lead paint, contaminated drinking water; and they were at the forefront of the fight against typhoid, small pox, cholera and tuberculosis.

But it was infant health and the stagnant birth rate that were to prove especially emotive, since military defeat in 1870 and the widely publicised decline in live births in the 1890s seemed proof to many observers of moral and national decline. The extra-parliamentary pressure group founded in 1896 by Dr Jacques Bertillon, the national alliance for raising the birth rate, hoped to channel this diffuse sense of crisis to legislative ends by softening up both medical and political opinion on the issue. Bertillon's lobbying campaign for taxes on childless couples led to nothing, but his proposals were debated in parliament and the 1902 extra-parliamentary

commission on depopulation, over half of whose membership comprised sympathetic physicians, was set up on his instigation. By 1920 natalists formed the largest parliamentary interest group, helping to explain how the Bill introduced in that year to curtail the practice of contraception and abortion could pass with minimal discussion.

But it is important to remember that none of these medical campaigns was wholly uncontroversial. Many (even those that now seem simple common sense to us) faced significant political opposition or flew in the face of longstanding and accepted conventional wisdom about health and disease. The medical practitioners who sought improvements in public health needed to recruit influential supporters, willing to listen to and weigh up the research available. Importantly, by taking their issues to Parliament these public health initiatives were scrutinized from both a scientific perspective, and in the light of prevailing attitudes about what regulation of the individual the State could and should support. Furthermore, the voices of doctors were not the only ones struggling to be heard, and they were certainly not always determinative. What influence they had depended on a range of structural and ideological factors, and on how far doctors were trusted culturally, a nebulous status that drew as much on their claims to understand human suffering as their scientific credentials.

The history of medical lobbying shows that many of the public health laws that sought to combat the spread of infectious diseases, improve sanitation or offer medical assistance to the poor, originated in quite deliberate campaigns on the part of doctors, acting individually or in professional groups, to effect legislative change. This process also forced medical campaigners to present their research in ways accessible to the non-expert legislator, and to subject it to broad scrutiny in order to be persuasive in a policy context. It appears that this kind of activity became routine, and that it was accepted by political elites and the wider public alike.

Advocacy by the health community is especially important because the nature of disease is changing. The global health challenges of the 21st century are distinct from those of the past – principally unhealthy behaviours related to smoking, alcohol and obesity. Such ill health is linked to unhealthy environments in part created by commercial operators who spend large sums marketing their brands, leading to industrial epidemics of non-communicable disease. According to their annual reports, the spirits producer Diageo spent £1,629 million on marketing from sales of £10,813 million in 2015, and the ‘market place spend’ of Pepsico amounted to \$34.7 billion from global sales of \$66 billion in 2013. Pressure has been brought to bear on governments, too. Lobbying by the UK drinks industry recently resulted in a complete turnaround on alcohol policy with the revoking of the 2% above inflation duty escalator and the defeat of minimum unit pricing, despite the enormous cost to the exchequer, running into billions of pounds.

All of this makes the opposition that the UK cabinet office has drawn between lobbying and the pursuit of ‘good causes’ seem not only ill-conceived, but dangerously counter-productive.

Bibliography

Jack Ellis, *The Physician-legislators of France: medicine and politics in the early Third Republic, 1870-1914*, (Cambridge University Press, 1995)

Joshua Cole, *The Power of large numbers: population, politics, and gender in nineteenth-century France*, (Ithaca and London: Cornell University Press, 2000)

Imogen Goold and Catherine Kelly, (eds.) *Lawyer’s Medicine: the legislature, the courts and medical practice, 1760-2000*, (Oxford: Hart Publishing, 2009)

Rob Moodie, David Stuckler , Carlos Monteiro, et al. ‘Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries’, *Lancet* 2013; 381(9867): 670-9

Dorothy Porter and Roy Porter, 'The Politics of prevention: anti-vaccinationism and public health in nineteenth-century England', *Medical History*, vol. 32, 1988, pp. 231-252

Authors

Dr Catherine Kelly

Senior Lecturer, Law Faculty, University of Western Australia, and Honorary Senior Lecturer, University of Bristol Law School

Dr Joan Tumblety

Associate Professor, History, University of Southampton

Professor Nick Sheron

Head of Clinical Hepatology, Medicine, University of Southampton